APPLICATION FOR IOWA ACUPUNCTURE LICENSE

IOWA BOARD OF MEDICINE
400 S.W. 8th Street, Suite C, Des Moines, IA 50309-4686
515-281-6641

This application is used by individuals who are applying for an acupuncture license. Iowa licensed physicians, dentists, chiropractors, and podiatrists are permitted to practice acupuncture without obtaining an acupuncture license. For information about the requirements to practice acupuncture in your profession, contact the Iowa board that issued the license.

Instructions for Completing the Application

1. It is important to follow the instructions in each section of the application.

2. Do not leave sections of the application blank. If a section or an item within the section does not pertain to you, indicate that it is not applicable by placing an "NA" in the section or item.

2. Use the accompanying Checklist to complete the application. Not all forms in this packet will apply to all applicants.

3. For additional space to complete any section, attach a separate sheet of paper labeled with the appropriate section number. Sign and date each attached sheet.

Using this Application Form on the Computer

1. This application packet may be saved to your computer, because the application is a PDF file. To save this file, click on the icon that looks like a diskette. This toolbar should be located above the document.

2. When completing the application on the computer, you will not be able to save the information entered to print at a later time. Print any completed pages immediately.

3. Use the Tab Key to move from field to field.

4. Some of the fields allow multiple lines of text. Be sure that all text entered can be viewed when moving to the next field. Information that is not visible on the form will not be printed.

5. Some fields (such as the last name field) have word wrap due to the size of the field. Continue to type the information even though it may break to the next line. It may not look as nice, but it is necessary to get all the information visible on the application.

Section 1— Identifying Information

Complete every item. Enter your full legal name. Do not enter an initial for your middle name, unless an initial is your legal middle name. Licenses are issued in the acupuncturist's legal name. List other names you have used, such as a nickname or name that is used on the diploma, if different from your legal or maiden name. Describe any identifying marks, such as scars, birthmarks, or tattoos. An e-mail will be sent to the applicant's e-mail address and the other e-mail address listed after a review of the application is completed. The other e-mail address can be for the person assisting you with the application process.

Full Legal Name:

Last First Middle Suffix

Other Name(s) Used: ☐ Check if Not Applicable | **Maiden Name:**

Current Home Address:
Street, City, State, Zip
(County– for Iowa addresses only)

Home Phone:

Current Work Address:
Street, City, State, Zip,
(County– for Iowa addresses only)

Work Phone:

Applicant E-mail:

Other E-mail:

Mailing/ Website Address: This address will be the address used for all correspondence from this office and will be displayed on our website with your license information.

☐ Work ☐ Home

Social Security Number:

Privacy Act Notice: Disclosure of your Social Security Number on this license application is required by 42 U.S.C. Section 666(a)(13) and Iowa Code Section 252J.8(1). The number will be used in connection with the collection of child support obligations and as an internal means to accurately identify licensees, and may be shared with taxing authorities as allowed by law including Iowa Code Section 421.18.

Height: ft in | **Weight:** lbs | **Hair Color:** | **Eye Color:**

Identifying Marks: ☐ Check if not applicable

U.S. Citizen? ☐ Yes ☐ No

If No, Visa Type or Alien Registration Number:

Applicant Name:

Section 2—Birth Information

Complete every item. Provide your date of birth in month/day/year format.

Date of Birth:	**City of Birth:**
State of Birth:	**Country of Birth:**
Father's Full Name:	
Mother's Full Name:	

Section 3—Acupuncture Education

List all acupuncture schools you have attended, even those you did not graduate from. Provide an explanation below if 1) it took longer than four years or fewer than three years to complete your acupuncture education, 2) had a break in your acupuncture education, or 3) the end date of your education is different than the date of your degree.

Institution	City, State, Country	From (Mo/Yr)	To (Mo/Yr)

Degree Received: **Date of Degree (Mo/Yr):**

A copy of my diploma is submitted herewith. I further state that I am the identical person to whom this diploma was granted, that the same was procured in the regular course of study without fraud or misrepresentation and that the copy presented is a true copy.

Explanation:

Applicant Name:

Section 4—Chronology of Activities

Provide a chronological listing of all acupuncture and non-acupuncture activities from the date you entered acupuncture school to the present date, with no gaps in time. Do not substitute a resume or a curriculum vitae for this section. Include exact nature, location, and time frame of each activity. For any non-working time, you must state on the form exactly what your activities were such as "vacation" or "seeking employment." Applicants may copy this page or attach additional sheets of paper, labeled with your name and signed by you, if more space is needed.

Activity	Location (City/State)	From (Mo/Yr)	To (Mo/Yr)

Applicant Name:

Section 5—Hospital Privileges

List hospitals where you were granted privileges within the last five years. Do not guess on the dates of your privileges; verify the dates with the facility prior to completing the application. You will be required to correct any incorrect dates.

☐ Not Applicable, check here if you have not held any hospital privileges that were not part of your training program.

Hospital Name	Address	From (Mo/Yr)	To (Mo/Yr)

Applicant Name:

Section 6— Acupuncture License Information

List all state and Canadian provinces where you currently hold or have held any type of acupuncture license/registration. Do not guess on the license number or original issue date of your license, verify the information with the licensing agency prior to completing the application. You will be requested to correct any incorrect information.

☐ Not Applicable, check here if you have never held any acupuncture licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type (i.e. Training, Permanent)

Section 7— Other Professional License Information

List all state and Canadian provinces where you currently hold or have ever held any professional license, such as a chiropractic, nursing, or physician assistant license.

☐ Not Applicable, check here if you have not held any other professional licenses.

State/Country	License Number	Original Issue Date (Mo/Yr)	License Type & Profession (i.e.Training/Nurse)

Applicant Name:

Section 8—Examination Information
Provide the requested information.

◯ **Yes**	◯ **No**	Do you hold evidence of current active status as a diplomate in the National Commission for Acupuncture and Oriental Medicine (NCCAOM)? List Certificate Program: Issue Date: Expiration Date:
◯ **Yes**	◯ **No**	Did you obtain NCCAOM certification by examination?
◯ **Yes**	◯ **No**	Did you obtain NCCAOM certification by document review?
◯ **Yes**	◯ **No**	Do you hold evidence of completion of clean needle technique by the NCCAOM?

In what language did you take the NCCAOM written examination?

In what language did you take the NCCAOM practical examination?

Section 9—Practice Information
List your proposed Iowa practice. If it is unknown, please explain.

Proposed Iowa Practice Address:
(Institution/Group, Street, City, State, Zip Code)

Applicant Name:

Section 10— Question Definitions

It is important to review the definitions below before answering the questions in this section.

"Ability to practice acupuncture with reasonable skill and safely" means all of the following: The cognitive capacity to make appropriate clinical diagnoses, to exercise reasoned acupuncture judgments and to learn and keep abreast of acupuncture developments; The ability to communicate acupuncture judgments and information to patients and other health care providers; and The capability to perform acupuncture tasks , with or without the use of aids or devices.

"Medical condition" means any physiological, mental or psychological condition, impairment or disorder, including drug addiction and alcoholism.

"Chemical substances" means alcohol, legal and illegal drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" The medical condition has had an ongoing or adverse impact on the ability to function and practice.

"Improper use of drugs or other chemical substances" means all of the following: The use of any controlled drug, legend drug or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and the use of any substance, including, but not limited to, petroleum products, adhesive products, nitrous oxide and other chemical substances for mood enhancement.

"Illegal use of drugs or other chemical substances" means the manufacture, possession, distribution or use of any chemical substances prohibited by law (e.g. heroin).

Iowa Physician Health Program (IPHP)

The IPHP is a confidential, voluntary program offered to acupuncturists who may be dealing with impairment issues, such as, but not limited to alcohol or drug abuse, dependency or addiction, neuropsychiatric disorder, or physical disability. The IPHP develops an individualized program for each physician, with the goal of allowing the acupuncturist to continue to practice with reasonable skill and safety. Oftentimes, the Licensure Committee of the Board will refer physicians with impairment issues to the IPHP for review and bases licensure decisions on its recommendations.

To self-report to the IPHP or obtain additional information, contact the Coordinator of IPHP at 515-281-6491.

Applicant Name:

Section 10—Questions

Respond "yes" or "no" to each item. The Board expects full disclosure of events, whether you consider them to be minor or major in nature. It is better to disclose information than to not disclose it.

For every "yes" response, you must provide a separate statement of explanation that is signed and dated. This statement must include full details, including dates, locations, actions, organizations or parties involved. You must also provide the requested supporting documentation. The Board may request additional supporting information, if needed.

Applicants must answer all questions. Current IPHP participants, may answer "No" to questions 1 through 5.

Yes	No	
○	○	1. Do you currently have a medical condition which in any way impairs or limits your ability to practice acupuncture with reasonable skill and safety? **If yes**, provide a description of your condition and submit the "Verification of Medical Condition" form which is to be completed by your treating physician(s).
○	○	2. Are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? **If yes**, provide details of your treatment or program, copies of treatment evaluations, statement from the program indicating your progress and practice recommendations.
○	○	3. Does your field of practice, or the setting or the manner in which you have chosen to practice medicine, reduce or eliminate the limitations or impairments caused by your medical condition or use of alcohol, drugs or other chemical substances? **If yes**, provide a description of your practice and how it has changed since the diagnosis of your medical condition.
○	○	4. Are you currently engaged in the illegal or improper use of drugs or other chemical substance? **If yes**, provide an explanation.
○	○	5. Does your current use of alcohol, drugs or other chemical substances in any way impair or limit your ability to practice medicine with reasonable skill and safety? **If yes,** explain your current usage and how this impairs your ability to practice.

Applicant Name:

Yes	No	
○	○	6. Have you ever been convicted of, or entered a plea of guilty, nolo contendere, or no contest to a crime other than a minor traffic offense, in any jurisdiction? You must include all misdemeanors and felonies, even if adjudication was withheld by the court so that you would not have a record of conviction. (For example, you must report if your conviction was expunged, you received a deferred judgment, or you received an executive pardon.) Driving under the influence or driving while impaired is not a minor traffic offense. **If yes**, provide details of the charge and the final outcome. Provide copies of any court/legal documents related to each incident.
○	○	7. During acupuncture school, were you ever terminated, requested to withdraw, or placed on probation? **If yes**, provide an explanation.
○	○	8. Have you ever received a certificate of non-compliance from the College Student Aid Commission regarding non-payment of a student loan? **If yes,** provide an explanation.
○	○	9. Have you ever been terminated, asked to withdraw, or asked to repeat a portion of an acupuncture training program? **If yes,** provide an explanation.
○	○	10. Have you ever received a warning or reprimand, been asked to participate in remediation or been placed on probation during an acupuncture training program? **If yes**, provide an explanation.
○	○	11. Have you ever taken a leave of absence for any reason (maternity, family, personal, financial) during your acupuncture education? **If yes**, provide an explanation.
○	○	12. Have you ever been denied a license to practice acupuncture or a license to practice another profession? **If yes,** provide an explanation and a copy of the notice of denial.
○	○	13. Have you ever surrendered any professional license for any reason? **If yes,** provide an explanation and a copy of all official documents relating to the surrender.
○	○	13a. If yes, was a license disciplinary action pending against you or were you under investigation by a professional licensing agency at the time you surrendered the license? **If yes,** provide an explanation and a copy of all related official documents.
○	○	14. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate? **If yes,** provide an explanation and a copy of the notice of denial.

Applicant Name:

Yes	No	
○	○	15. Have you ever surrendered your state or controlled substances registration or had it restricted in any way? **If yes,** provide an explanation and a copy of all official documents relating to this.
○	○	16. Aside from ordinary initial requirements of proctorship, have you had your privileges or staff status at any hospital or health care entity, nursing facility, clinic, or other professional health care organization ever been limited, suspended, revoked, not renewed, voluntarily relinquished, denied, or subject to other disciplinary or probationary conditions? **If yes,** provide an explanation and a copy of all related official documents.
○	○	17. Have you ever been terminated, sanctioned, penalized, had to repay monies to or been denied provider participation in any Medicaid, Medicare or other publicly funded healthcare program? **If yes,** provide an explanation and a copy of all related official documents.
○	○	18. Have you ever been denied membership or renewal or been subject to any disciplinary action, sanction or warning in any medical or osteopathic organization or professional society? **If yes,** provide an explanation and a copy of all related official documents.
○	○	19. Have you ever been investigated or subject to an inquiry/review by any professional licensing agency, including investigations or reviews which resulted in no formal action? (Answer "Yes" if you have ever been contacted by an investigator or Board agent to review a complaint or report filed against you.) **If yes,** provide an explanation of the inquiry, including dates, state, charges, final outcome and a copy of all related official documents
○	○	20. Has any jurisdiction of the U.S. or other nation ever limited, restricted, warned, censured, placed on probation, suspended, revoked or filed charges against any license you held? **If yes,** provide an explanation and a copy of all related official documents.
○	○	21. Are you in violation of any child support order or written agreement to pay child support? **If yes,** provide an explanation.
○	○	22. Have any professional liability suits ever been filed against you? **If yes,** complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.
○	○	23. Have any judgments or settlements been paid on your behalf as a result of a professional liability case? **If yes,** complete the attached Professional Liability Suit Information form along with a copy of the requested legal documents listed on that form.

Applicant Name:

Section 11— Affidavit of Applicant

Enter the state and county in which the affidavit is being notarized. Sign the affidavit in the presence of a notary. The notary must supply the jurisdiction at the beginning of the affidavit, sign, enter the date of the notarization, and the expiration date of his/her commission. Attach a recent photo of yourself that has been taken within the last 90 days.

State of: _____ **County of:** _____

I,_____

hereby swear or affirm, under penalty of perjury, that I am the person described and identified; that the attached photo is a true likeness of myself; that I am the person named in the diploma which accompanies this application; that I am the lawful holder of said diploma; that said diploma was procured in the regular course of instruction and examination without fraud or misrepresentation.

I certify that I have carefully read the questions on this application and have answered them completely and truthfully. I declare under penalty of perjury that my answers, and all other statements or information submitted by me in this application process, are true and correct. If it is determined at any time that I have provided misleading or false information on or in support of this application, I understand that my application may be denied or that I may be subject to disciplinary action and criminal prosecution if I am already licensed.

I understand that I am required to update answers or information submitted with this application if the response or the information changes during the time period the application is pending. I also understand that this application is a public record in accordance with Iowa Code chapter 22 and that application information is public information, subject to the exceptions contained in Iowa law. Finally, in submitting this application, I consent to any reasonable inquiry that may be necessary to verify the information I have provided on or in conjunction with this application.

I also declare, under penalty of perjury, that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer and take full responsibility for all answers contained in this application.

_____

Signature of Applicant

_____

Signature of Notary Public

_____

Sworn/Affirmed to before me on

_____

My commission expires:

_____

Notary Seal or Stamp:

ATTACH A RECENT PHOTO THAT HAS BEEN TAKEN WITHIN THE LAST 90 DAYS HERE

Office Use Only
License Number: _____
Issue Date: _____
Expiration Date: _____
Initials: _____

Applicant Name:

Section 12— Authorization for Release of Information
All applicants must sign and date this section.

I, _____(print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Acupuncturist Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

Applicant Name:

Checklist for Iowa Acupuncture License

Provide or complete each item listed below. Not all items are needed for all licensure applications. Using the checklist will ensure a complete license application is submitted.

Do not send this form back to the Iowa Board of Medicine.

Application Items
Enclose the Correct Fee—$300. Fee is non-refundable. Make check or money order payable to the Iowa Board of Medicine.
Complete each section of the application.
Transcript of Acupuncture Education. Request an official transcript of your acupuncture education to be sent directly to this board from your acupuncture school(s).
Verification of Hospital Privileges <u>in</u> the U.S. or Canada within the last five years. Submit attached verification form to hospital(s) for completion.
Verification of U.S. or Canadian License(s). Submit attached verification form to state licensing agency for completion to verify acupuncture license or other professional licenses.
NCCAOM Status Report & Examination Results. Request a status report and transcript of your examination results from the NCCAOM to be sent directly to this board.
Mandatory Disclosure Sheet. Submit a copy of the mandatory disclosure sheet for your proposed Iowa practice. The disclosure sheet must include the following information. • Name, business address, and business phone number, and fee schedule. • Listing of your education, experience, degrees, certifications, or other credentials related to acupuncture awarded by professional acupuncture organizations, length of time required to obtain degrees or credentials, and experience. • Statement indicating any license, certificate, or registration in a health care occupation which was revoked by any local, state, or national health care agency. • Statement that you are complying with statutes and rules adopted by this Board and that only pre-sterilized, disposable needles are used. • Statement that the Iowa Board of Medicine regulates the practice of acupuncture. • Statement indicating that a license to practice acupuncture does not authorize a person to practice medicine and surgery in Iowa, and that the services of an acupuncturist must not be regarded as diagnosis and treatment by a person licensed to practice medicine and must not be regarded as medical opinion or advice. • Provide a space for the patient's signature and date.
Copy of Diploma. Submit a copy of your diploma. An official translation is needed for any diploma not in English.
Copy of Acupuncture License. Submit a copy of any acupuncture license you hold.
Change of Address Contact board staff to update your record if a change of address occurs during the licensure process.

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Hospital Privilege Verification

Applicant: Submit this form to each hospital where you held privileges within the last five years. Complete the top portion and page two of the form only and submit the form to the hospital.

Hospital: Complete and mail the form directly from the hospital to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Applicant)

had hospital privileges at _____
(Name of Hospital)

located at _____
(Address, City, State, Zip, Country)

From _____ To _____
(Month/Year) (Month/Year)

Was any disciplinary action ever taken against the applicant?
Yes_____ No_____
If yes, provide details of the disciplinary action and a copy of any documentation related to the event.

Is there any derogatory* information on file?
Yes_____ No_____
If yes, provide details of the derogatory information and a copy of any documentation related to the event.
*Derogatory information can include probation, investigation, remediation, and/or other disciplinary actions.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by the Medical Staff Office:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information—Hospital Privilege Verification

The applicant must sign this form and submit it with the Hospital Privilege Verification form. The hospital may retain this release of information for their own records.

I, _____(print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Acupuncturist Date

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400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Professional Licensure Verification

Applicant: Submit this form to each jurisdiction where you were issued a license. Complete the top portion and page two of the form only and submit the form to the appropriate licensing agency.

State or Provincial Licensure Board: Complete and mail the form directly to the Iowa Board of Medicine. Any processing fees are the applicant's responsibility.

Applicant's Name (Print Legibly): _____

Applicant's Date of Birth (Month/Day/Year): _____

It is hereby certified that _____
(Name of Licensee)

Date of Birth: _____ Profession: _____ Issued License Number: _____

By _____ On _____
(State or Province) (Month/Year)

License Type: Permanent _____ Training/Educational _____ Temporary _____ Other _____

Has the licensee ever been investigated or had a complaint filed against him/her?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the investigation or complaint.

Has disciplinary action ever been initiated, invoked, or is disciplinary action pending?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to the disciplinary action.

Has the licensee ever voluntarily relinquished their license?
Yes _____ No _____ Unable to Disclose _____
If Yes, provide a copy of the documentation related to this event.

Institutional Seal

If the institution does not have an official seal, the form must be notarized.

Completed by State or Provincial Licensure Board:

Print Name: _____

Signature: _____

Date (month/day/year): _____ Phone: _____

Fax: _____ E-mail: _____

Authorization for Release of Information-Verification of Licensure

The applicant must sign this form and submit it with the Verification of Licensure form. The licensing agency may retain this release of information for their own records.

I, _____(print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not limited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

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Signature of Acupuncturist Date

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Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Professional Liability Suit Information

Applicant: Complete this form each suit you have been named a party. Summaries of this information from insurance carriers is not acceptable. Submit the requested documentation for each suit. You do not need to submit this form if you have not been named in a professional liability suit.

Name of patient/plaintiff:

Date of event:

Date of suit:

Does the suit involve any of the following?

Yes	No	
☐	☐	Death of the patient
☐	☐	Wrong sided surgery
☐	☐	Loss of limb or major organ

What is/was your role in the suit or claim:

- ☐ Primary defendant
- ☐ Co-defendant
- ☐ Other

Status of Suit & Documents to Submit:

- ☐ Pending—Submit copy of complaint and a letter from your attorney indicating the status of the case.
- ☐ Dismissed—Submit copy of the dismissal order.
- ☐ Settled— Submit copy of complaint, final disposition, and settlement/release.
  Amount Settled on Your Behalf_____
- ☐ Other

Describe the allegations:

Describe your involvement in the care of the patient:

Applicant Name (Print Name): _____

Applicant Signature: _____ **Date:** _____

Iowa Board of Medicine
400 SW 8th Street, Suite C, Des Moines, IA 50309-4686
(515) 281-6641 www.medicalboard.iowa.gov

Verification of Medical Condition

Applicant: You are required to provide a statement explaining any medical condition you have experienced that has had an ongoing or adverse impact on your ability to function and practice. Acupuncturists who had a condition that interrupted their education or training should also complete this form.

The physician who diagnosed and provides, or provided, treatment for the condition should complete the form.

Treating Physician: Complete and mail the form directly to the Iowa Board of Medicine. This form is also on our website as a pdf document which can be completed using the computer and printing the document. The applicant's signature on page three of this form authorizes the release of information, favorable or otherwise, directly to the Board.

Applicant's Name (Print Legibly):_____

Applicant's Date of Birth (Month/Day/Year):_____

Nature of Medical Condition (include specific diagnosis):

Summary of Treatment:

Treatment Period: From To

Recommended Treatment:

Is/Was the applicant in compliance with his/her treatment? **Yes** ☐ **No** ☐
If no, please explain.

Is the applicant taking any prescribed medications for this condition? **Yes** ☐ **No** ☐
If yes, please list the medication(s).

Provide a summary of other prescription medications this applicant is taking.

Has this medical condition in any way affected the applicant's ability to practice acupuncture with reasonable skill and safety? **Yes** ☐ **No** ☐
If yes, please explain.

Do any limitations need to be in place with regard to the applicant's practice of acupuncture?
Yes ☐ **No** ☐
If yes, please explain.

If treatment were to cease for any reason, could the applicant's condition in any way affect his/her ability to practice acupuncture with reasonable skill and safety? **Yes** ☐ **No** ☐
If yes, please explain.

Is ongoing monitoring warranted? **Yes** ☐ **No** ☐
If yes, please explain.

Treating Physician Information:

Name (print legibly): _____

Signature: _____ **Date:** _____

Address: _____

Phone: _____ **Fax:** _____

Authorization for Release of Information-Verification of Medical Condition

The applicant must sign this form and submit it with the Verification of Medical Condition form. The treating physician may retain this release of information for his/her own records.

I, _____(print name), do hereby authorize a disclosure of records concerning myself to the Iowa Board of Medicine (IBM). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IBM may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IBM relating to substance abuse or dependence and/or mental health.

I further agree that the IBM may receive confidential information and records, including, but not l imited to the following records:

- Medical Records
- Education Records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Post-graduate training (internship, residency, & fellowship) records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IBM deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any medical school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IBM pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IBM, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is valid until completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IBM has already taken action in reliance upon this consent.

I have read and fully understand the contents of this "Authorization to Release Information."

_____ _____

Signature of Acupuncturist Date

PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/ drug abuse or mental health information.